TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS IMPAIRMENT EXAM
TRENTON D WEEKS DC

Respondent Name
TECHNOLOGY INSURANCE CO

MFDR Tracking Number
M4-17-1661-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I performed this examination at the request of the injured employee and the treating doctor...This examination was performed for the purpose of determining MMI and Impairment as it related to the work injury of [date of injury]."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...Respondent file a PLN-1 denying the Claimant's alleged injured of [date of injury] in its entirety. On 1/12/17, a CCH Decision and Order was issued which found Claimant did not sustain a compensable injury on [date of injury]. It further stated the Carrier was not liable for benefits. Respondent denied the medical bill in dispute based on entitlement to benefits. Because the Claimant did not sustain a compensable injury on [date of injury], the Claimant is not entitled to any benefits, including medical benefits. Therefore, Respondent is not liable for payment of the medical bill in dispute as there is no compensable injury."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 26, 2016	99456-NM	$350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W11 – Entitlement to benefits. Not finally adjudicated

Issues

1. Has the compensability issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. The Requestor seeks reimbursement for a treating doctor/injured employee requested MMI/IR rendered on February 26, 2016. Pursuant to 28 Texas Administrative Code §133.305(a)(4) a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." The insurance carrier submitted a copy of a Contested Case Hearing Decision dated January 10, 2017 to support that the compensability issue has been resolved.

   The services in dispute were denied, in part, due to "W11 – Entitlement to benefits. Not finally adjudicate." The disputed issue involved whether the injury was accepted as a compensable injury. A Contested Case Hearing dated January 10, 2017 concluded that the "Claimant did not sustain a compensable injury on [date of injury.] The division concludes that the injury was not accepted as a compensable injury by the Division.

2. Review of the documentation submitted indicates that the provider billed for services rendered for the date of injury that was found to be non-compensable. As a result, per 28 Texas Administrative Code §133.305(a) (4) the requestor is not entitled to reimbursement for services rendered for an injury that was determined by the Division to be non-compensable.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 24, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** along with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.